

Architecture, Religion, and Tuberculosis in Sainte-Agathe-des-Monts, Quebec

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Résumé de l'article

Cet article explore l'architecture du 'Mount Sinai Sanatorium' situé à Sainte-Agathe-des-Monts (Qc) dans le but d'éclaircir le rôle de la religion dans le traitement de la tuberculose. Plus particulièrement, nous offrons une analyse du design de cet édifice, le joyau de la philanthropie juive montréalaise, en relation avec le 'Laurentian Sanatorium' situé à proximité. Alors que le 'Mount Sinai' offre des traitements gratuits pour les pauvres dans un étonnant édifice Art déco des années 1930, l'hôpital protestant pourvoit dès 1908 des services à ses clients payants dans un décor de résurgence Tudor, conçu comme un second 'chez-soi'. Empruntant à l'historien de l'architecture Bernard Herman le concept d'*embedded landscapes*, nous démontrons en quoi les deux hôpitaux diffèrent dans leur rapport au site, à l'accès, et, plus substantiellement, à la ville, à la connaissance et à la communauté. Les architectes Scopes et Feustmann, qui ont conçu le 'Laurentian', opéraient un bureau à Sarnac Lake, New York, première destination américaine pour les tuberculeux. Les qualifications des architectes du 'Mount Sinai', Spence et Goodman, dérivent en contrepartie de leur expérience avec des institutions juives montréalaises. À partir de l'approche de l'architecture de Herman, nous nous interrogeons sur la place de la thérapie médicale et du judaïsme dans les plans du 'Mount Sinai'.

Architecture, Religion, and Tuberculosis in Sainte-Agathe-des-Monts, Quebec¹

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Abstract: This paper explores the architecture of the Mount Sinai Sanatorium in Sainte-Agathe-des-Monts (Qc) to disentangle the role of religion in the treatment of tuberculosis. In particular, we analyze the design of Mount Sinai, the jewel in the crown of Jewish philanthropy in Montreal, in relation to that of the nearby Laurentian Sanatorium. While Mount Sinai offered free treatment to the poor in a stunning, Art Deco building of 1930, the Protestant hospital had by then served paying patients for more than two decades in a purposefully home-like, Tudor-revival setting. Using architectural historian Bernard Herman's concept of *embedded landscapes*, we show how the two hospitals differed in terms of their relationship to site, access, and, most importantly, to city, knowledge, and community. Architects Scopes & Feustmann, who designed the Laurentian hospital, operated an office at Saranac Lake, New York, America's premier destination for consumptives. The qualifications of Mount Sinai architects Spence & Goodman, however, derived from their experience with Jewish institutions in Montreal. Following Herman's approach to architecture through movement and context, how did notions of medical therapy and Judaism intersect in the plans of Mount Sinai?

Résumé : Cet article explore l'architecture du 'Mount Sinai Sanatorium' situé à Sainte-Agathe-des-Monts (Qc) dans le but d'éclaircir le rôle de la religion dans le traitement de la tuberculose. Plus particulièrement, nous offrons une analyse du design de cet édifice, le joyau de la philanthropie juive montréalaise, en relation avec le 'Laurentian Sanatorium' situé à proximité. Alors que le 'Mount Sinai' offre des traitements gratuits pour les pauvres dans un étonnant édifice Art déco des années 1930, l'hôpital protestant pourvoit dès 1908 des services à ses clients payants dans un décor de résurgence Tudor, conçu comme un second 'chez-soi'. Empruntant à l'historien de l'architecture Bernard Herman le concept d'*embedded landscapes*, nous démontrons en quoi les deux hôpitaux diffèrent dans leur rapport au site, à l'accès, et, plus substantiellement, à la ville, à la connaissance et à la communauté. Les architectes Scopes et Feustmann, qui ont conçu le 'Laurentian', opéraient un bureau à Saranac Lake, New York, première destination américaine pour les tuberculeux. Les qualifications des architectes du 'Mount Sinai', Spence et Goodman, dérivent en contrepartie de leur expérience avec des institutions juives montréalaises. À partir de l'approche de l'architecture de Herman, nous nous interrogeons sur la place de la thérapie médicale et du judaïsme dans les plans du 'Mount Sinai'.

1. Thank you to Barry Crewe, Valerie Minnett, Joseph Rothbart, Janice Rosen, David Theodore and Julia Tischer. Funding for this research came from SSHRC.

Hiss of silken garments. Murmuring of sympathetic words: “We must conduct a fund-drive very soon! Poor souls – four and five in a single room! We must conduct a big campaign – we need a place where every windowpane will glisten in the sunshine: where every room will have sufficient light and air. And the chapel here is much too small. You can barely turn around among the benches there – it’s like a stall!” Glances pityingly caress the critically ill, prone upon gleaming beds.²

In his novel in verse, *Dos Vayse Hoyz* or *The White House*, Yiddish writer Sholem Shtern describes a visit to Mount Sinai Sanatorium by members of the women’s auxiliary, who diligently scrutinize the patients, the wards, and the synagogue. Their monthly sojourns to assess and improve treatment services allow them to perform a *mitzvah*, a word that strictly means a divine commandment, but which nowadays is used to describe any good deed. These regular visitors conclude that a new sanatorium is needed in order to reduce overcrowding and to improve two fundamental aspects of therapy, access to fresh air and to light. The women’s *mitzvot*—their good deeds—thus link architectural design and Judaism to the ideals of tuberculosis treatment.

This article explores the architecture of the Mount Sinai Sanatorium (fig. 1) in Sainte-Agathe-des-Monts, Quebec, as a way to evaluate the role of religion in the treatment of tuberculosis. To isolate the significance of Judaism in particular, we compare the design of Mount Sinai Sanatorium, the jewel in the crown of Jewish philanthropy in Montreal, to its Protestant counterpart, the nearby Laurentian Sanatorium. Because these hospitals were established in the same town and shared human and material resources, the comparison provides a unique opportunity to explore the relationship of religion, architectural design, and medical treatment. Mount Sinai and the Laurentian Sanatorium share many characteristics that allow for an equitable basis of comparison. Both were constructed in Ste-Agathe, a small town in the Laurentian Mountains, 96 kilometres north-west of Montreal. Ste-Agathe’s position 457 metres above sea level ensured its clean country air, described in 1900 as being like champagne.³ Their respective founders, tobacco-baron Sir Mortimer Davis (1866-1928) and rubber-baron Douglas Lorne McGibbon (1870-1927), came from the same social class, were successful industrialists, attended the prestigious High School of Montreal, and built neighbouring grand, stone country homes in Ste-Agathe.

2. Sholem Shtern, “The Ladies Come to Visit,” in *The White House: A Novel in Verse*, translated by Max Rosenfeld (Montreal and New York: Warbrooke Publishers, 1974), 93-4. Originally published as *Dos Vayse Hoyz* (New York: YKUF, 1967).

3. Elizabeth Wand, *Quisisana* (Ste. Agathe des Monts: [n.p.], 1900), 8.

Figure 1. Mount Sinai Sanatorium was designed by Montreal architects Spence & Goodman.



Source: Mount Sinai Hospital Centre [hereafter MSHC] Archives, Box 17, Photographs.

Our study builds on American architectural historian Bernard Herman's concept of "embedded landscapes," which he devised by combining Ian Hodder's work in contextual archaeology and architectural historian Dell Upton's methods for studying movement and power in eighteenth-century Virginia churches and plantation houses. Herman's article "The Embedded Landscapes of the Charleston Single House, 1780-1820" shows how the celebrated Charleston single house expressed and enforced social hierarchy in a black majority urban slave society through relationships that were etched in the distinctive house plan.⁴ He also shows how inside the house the dining table, game table, and tea table functioned like the plan of the mercantile city. For example, Herman explains how the aesthetic investment in the Charleston parlour inspired an "archaeology of etiquette revolving around competitive and convivial exchange relations."⁵ The disciplinary framework of material culture allows Herman to look outside the house too, exploring the relationship of the house with outbuildings and the street.

As a scholar in vernacular architecture studies, Herman depends on both rigorous archival research and on-site fieldwork, including intrasite and intersite analysis. Through on-site fieldwork at Ste-Agathe we investigated the spatial relationships inferred from architectural drawings. We found the original plan of the Laurentian Sanatorium (now known as the *Centre*

4. Bernard L. Herman, "The Embedded Landscapes of the Charleston Single House, 1780-1820," in *Perspectives in Vernacular Architecture, VII*, eds. Annmarie Adams and Sally McMurry (Knoxville: University of Tennessee Press, 1997), 41-57.

5. *Ibid.*, 49.

Hospitaller Laurentien) among the institution's planning records, while Mount Sinai's first floor plan was published in the magazine *Canadian Hospital* in 1932. We undertook our fieldwork at a moment when Mount Sinai Sanatorium was abandoned and its future in doubt; sadly, the historic hospital was demolished in February 2005, and with it an embodied heritage, including the architectural record of the significance of religion in the treatment of tuberculosis.

As we shall see, the differences between the institutions were as important as the characteristics they shared. In 1930, Mount Sinai offered free treatment to the poor and to those who qualified for state-funded subsidies in a stunning, Art Deco building. At that time the Laurentian served paying patients in a twenty-year-old, purposefully home-like, Tudor-revival setting.⁶ Moreover, we intend this study to contribute to the cultural history of tuberculosis.⁷ For two generations the oppressive disease was absent from family life in Europe and North America, but it has undergone a worldwide resurgence since 1985, perhaps inspiring a recent surge in historical research.⁸ Little scholarship, however, has focused on the relationship of architecture and tuberculosis.⁹ Using a multi-disciplinary

6. The Laurentian also had a growing number of government-subsidized patients. Indeed, by the end of the decade, more than half of the Laurentian's patients occupied subsidized beds; Royal Edward Institute, *Annual Report of the Royal Edward Institute for the Study, Prevention, and Cure of Tuberculosis* 28 (1938), 9.

7. On the history of tuberculosis in Canada, see Pat Sandiford Grygier, *A Long Way from Home: The Tuberculosis Epidemic Among the Inuit* (Montreal/Kingston: McGill-Queen's University Press, 1994); Katherine McCuaig, *The Weariness, the Fever, and the Fret: The Campaign against Tuberculosis in Canada, 1900-1950* (Montreal/Kingston: McGill-Queen's University Press, 1999), and George Jasper Wherrett, *The Miracle of the Empty Beds: A History of Tuberculosis in Canada* (Toronto: University of Toronto Press, 1977).

8. The recent history of tuberculosis is something of a growth industry. In *Captain of Death: The Story of Tuberculosis* (Rochester: University of Rochester Press, 1997), Thomas M. Daniel provides a well-balanced account of medical knowledge of the disease and its treatment. Barbara Bates, in *Bargaining for Life: A Social History of Tuberculosis, 1876-1938* (Philadelphia: University of Pennsylvania Press, 1992), and Sheila Rothman, in *Living in the Shadow of Death: Tuberculosis and the Social Experience of Illness in American History* (New York: Basic Books, 1994), explore illness narratives for a sense of how the disease was experienced by the individual. Finally, Katherine Ott, in *Fevered Lives: Tuberculosis in American Culture since 1870* (Cambridge, Mass.: Harvard University Press, 1996), and Georgina D. Feldberg, in *Disease and Class: Tuberculosis and the Shaping of Modern North American Society* (New Brunswick, NJ: Rutgers University Press, 1995), attempt to nuance social representations and class differences in incidence and discourse. McCuaig, situating Montreal in the Canadian context, centres her account on the methods of combat; she sees turning points in the systematic handling of tuberculosis among soldiers in both World War I and World War II.

9. Two exceptions are Margaret Campbell, "What Tuberculosis did for Modernism: The Influence of a Curative Environment on Modernist Design and Architecture," *Medical History* 49, 4 (2005): 463-88; Leslie Maitland, "The Design of Tuberculosis Sanatoria in Late

methodology coming from our interests in both architectural and social history, we argue that religion permeated the hospitals at multiple scales, driving the hospitals' exterior forms and ornamentation, interior arrangements, their situation in the landscape, and their services such as food production, preparation, and distribution.¹⁰ The architecture of these two hospitals shows the differentiated ways the institutions related to the city and to the community as well as the profound impact of religion on thinking about tuberculosis in the early twentieth century.

Mount Sinai and Jewish Montreal

Ste-Agathe attracted Jewish Montrealers throughout the twentieth century. Sir Mortimer Davis's and other wealthy and powerful Jewish families owned land there in the first decade of this century. The Mount Sinai Sanatorium, founded in 1909, originated in a two-story farmhouse that had been renovated into a 12-bed sanatorium, on 160 acres of land donated by the Jewish Colonization Association. A 40-bed wooden facility was erected on the sanatorium property in 1913. By the late 1920s, given the need to modernize the building owing to overcrowding, inadequate access to fresh air and daylight, as well as rundown conditions, the Jewish community raised funds to construct the 1930 Art-Deco building that is the focus of this study. Jewish boarding houses, hotels, and restaurants thrived in Ste-Agathe, catering in particular to families of patients at Mount Sinai Sanatorium.

According to its president, Abe Bronfman, Mount Sinai was the only Jewish sanatorium in Canada.¹¹ The Jewish community in early twentieth-century Montreal faced serious difficulties accessing social welfare services and health care. Non-Jewish institutions, preoccupied with other priorities, were ill-equipped to deal with Jewish newcomers who had fled

Nineteenth Century Canada," *Bulletin of the Society for the Study of Architecture in Canada* 14, 1 (1989): 5-13. A conference of the UK-based Society for the Social History of Medicine held in Sheffield, UK, in March 2002 brought together twenty researchers (including Adams) to present new approaches to this popular topic. "From Urban Penalty to Global Emergency: Current Issues in the History of Tuberculosis" included cultural history, nationalistic, developing-world, racial, bovine, and age-related research to tuberculosis, but little on design.

10. On architecture and medicine in general, see Annmarie Adams, *Architecture in the Family Way: Doctors, Houses, and Women, 1870-1900* (Montreal/Kingston: McGill-Queens University Press, 1996); Annmarie Adams, "Modernism and Medicine: The Hospitals of Stevens and Lee, 1916-1932," *Journal of the Society of Architectural Historians* 58, 1 (1999): 45-8; Anthony D. King, ed., *Buildings and Society: Essays on the Social Development of the Built Environment* (London: Routledge & Kegan Paul, 1980); Thomas A. Markus, *Buildings and Power: Freedom and Control in the Origin of Modern Building Types* (London and New York: Routledge, 1993).

11. "Mount Sinai Reduces T.B. In Community," *Gazette* [Montreal], 4 August 1949.

pogroms in Russia, oftentimes leaving family members behind, and arrived in Montreal traumatized by their ordeal.¹² Even though all large medical facilities had to accept patients regardless of ethnic or religious affiliation, other institutional priorities and anti-Semitism meant that hospitals did not provide services in Yiddish, which Eastern-European immigrants required, Jewish religious ceremonies, or food that met Jewish dietary laws. From its beginning, most patients at Mount Sinai Sanatorium were working-class, Yiddish-speaking Jews from impoverished intercity neighbourhoods bordering either side of Boulevard St-Laurent in the heart of the so-called rag trade (garment manufacturing district).¹³ In the new 1930 building, thirty-six wards could accommodate 114 patients, who were categorized by degree of illness and not by social class. Incipient cases and the very sick were allocated separate wards.

Self-help was at the core of Mount Sinai's funding plan. Mount Sinai's admission policy was predicated on the Jewish *mitzvah* of charity, a command to provide for those less fortunate. *Tzedakah*, based on the biblical commandment to love your neighbour as yourself, includes the notion of helping people to become self-sufficient enough to perform the *mitzvah* of charity themselves.¹⁴ Thus the administration argued that "the call of the sanatorium is the call of the poor consumptive begging us to give him a new lease of life: it is the call of many a poverty stricken family begging us to give them back the breadwinner, and it is a petition which is in our power to grant."¹⁵

12. Note that the newcomers of the Main did not share the same customs, attitudes, politics, and language of the Canadian-born Jews of Westmount: the "uptowners" and "downtowners" were worlds apart. Tamara Myers argues that the Jewish elites sought to contain social problems resulting from immigrants to avoid any negative publicity of the Jewish community which could threaten their precarious assertions of citizenship in Quebec. See "On Probation: The Rise and Fall of Jewish Women's Antidelinquency Work in Interwar Montreal," in *Negotiating Identities in 19th- and 20th- Century Montreal*, eds. Bettina Bradbury and Tamara Myers (Vancouver: UBC Press, 2005), 177.

13. Annual Reports (1913 to 1943) consistently show that needle trade workers made up the majority of consumptives treated at the institution. Moreover, 96 case files from the Jewish Welfare Department covering the years 1930 to 1958, now in the Archives of the Canadian Jewish Congress, give addresses of tuberculosis sufferers treated at the Mount Sinai Sanatorium. Most of them lived in the St Lawrence Boulevard corridor.

14. For more on Jewish charity in Canada, see Elizabeth Kirkland, "Unearthing the Role of Elite Jewish Women in Montreal, 1880-1920," unpublished paper given at the CHA conference, London, 2005. See also T.L. Smith, "Biblical Ideals in American Christian and Jewish Philanthropy, 1880-1920," *American Jewish History* 74, 1 (1984): 25-6; Joe King, *From the Ghetto to the Main: The Story of the Jews of Montreal* (Montreal: The Montreal Jewish Publication Society, 2000), 73; Morton Weinfeld, *Like Everyone Else... But Different: The Paradoxical Success of Canadian Jews* (Toronto: McClelland and Stewart, 2001), 181.

15. "Mt. Sinai Sanatorium," *The Canadian Jewish Times* [Montreal], 31 June 1912.

The sanatorium was subsidized largely by the Jewish community through subscription revenues, fundraising campaigns, and individual donations. The institution's annual reports advertised it as a sanatorium "For the Free Treatment of Consumptives," but free treatment was provided only to those who could demonstrate a frank inability to pay. As the hospital's admission policy explained: "Inasmuch as the sanatorium was established for the purpose of taking care of poor consumptives, that it be a regulation for the Admission and Dismissal Committee, in their consideration of applications, to give preference to those who are indigent and have no friends or relatives to support them."¹⁶ Extant files of the Jewish Welfare Department show that social workers investigating eligibility for subsidized admission to the sanatorium sought out, interviewed, and coaxed siblings, children, parents, and extended family members—even those living in far away places—to contribute toward a sick family member's care. Thus, fully subsidized care (free treatment) was limited to those without family or friends. Government funding slowly came to be an important source of revenue. In a 1914 letter to Quebec Premier Lomer Gouin seeking provincial assistance, the sanatorium's executive claimed that since its opening Mount Sinai staff had treated "without charge of any nature to the inmates, 209 men, women, and children, irrespective of creed, nationality or the condition of the applicant—whether incipient, advanced or moribund."¹⁷ By the early 1920s, the sanatorium benefited from regular government grants to help offset operating costs; after 1925, the provincial government offered subsidized care of indigent patients from funds obtained by an amusement tax levied in Montreal. Since the amount did not cover all of the costs, it behooved Mount Sinai to seek ways to make up the difference.¹⁸

16. Mount Sinai Hospital Centre (hereafter MSHC) Archives, Box 18, File 2, Historical Records, "Mount Sinai Hospital—Past, Present and Future—a story in progress," in *Celebration of the 70th Anniversary of the MSS*, 10 August 1982.

17. MSHC Archives, Box 18, File 2, Historical Records, 1914 Annual Report, 13.

18. In 1930, the average daily cost to maintain a patient in a sanatorium was \$3. Notwithstanding state provisions for those demonstrably indigent, families contributed \$150,733 or an average of \$93 each according to a report, "Anti-Tubercular Sanatoria" in *Annuaire du Quebec* (1930): 180. An examination of the Mount Sinai annual reports between 1925 and 1946 revealed that the sanatorium relied upon the Federation of Jewish Philanthropies to cover the difference between its expenditures and income derived in large part from provincial grants as well as donations, interest, and by 1938 profits from the sanatorium's poultry farm. Canadian Jewish Congress Charities Committee (CJCCC), MBI, Series B, Box 11, Annual Reports of the Federation of Jewish Philanthropies of Montreal and Constituent Societies, 1925, 1928-1946.

Doctors

Bernard Herman's quest to uncover embedded landscapes in the built environment advises moving from what he calls the "'material' part of material culture" to a broader interpretation of culture.¹⁹ Heeding this advice, we argue that the architectural evidence suggests patients at Mount Sinai benefited from advanced medical technology and world-class expertise. By 1930 the sanatorium featured quartz lamps, sterilizing, dental, and operating rooms, and an x-ray department that included a vault for storing x-ray film. Physicians' research was facilitated by laboratories, a fully-equipped medical library, and even a hutch (erected on the small island in front of the building) to breed laboratory rabbits and rats. Well-known physician and tuberculosis crusader Norman Bethune was invited to work there in the early 1930s. Bethune had himself been treated with collapse therapy (pneumothorax) at Saranac Lake in New York. In 1928 he moved to Montreal to work with Edward Archibald, a thoracic surgeon at the Royal Victoria Hospital. The outspoken Bethune was convinced that poverty was the true cause of tuberculosis, and thus must have felt at home at Mount Sinai.²⁰ In 1937, the sanatorium offered its first post-graduate summer course for physicians, modeled on the Trudeau School at Saranac Lake. Fifty-four doctors from across Canada attended the week-long course of lectures, demonstrations, and medical rounds given by both Mount Sinai and Laurentian medical staff, prominent visiting specialists such as Edgar Mayer of New York (director of Will Rogers Hospital and physician to Hungarian composer Béla Bartók) as well as the Dean of Medicine of McGill University (Grant Fleming) and representatives of the Provincial Department of Health (Edward Archibald and AR Foley). That same year, Mount Sinai also began a system of three-month rotating internships filled by physicians from the Jewish General Hospital in Montreal.²¹

19. Herman, 42.

20. For more on the life of Norman Bethune, see Larry Hannant, ed., *The Politics of Passion: Norman Bethune's Writing and Art* (Toronto: University of Toronto Press, 1998); Dominique Hoizey, "Centenaire de la naissance de Norman Bethune (1890-1939) médecin canadien," *Histoire des Sciences Médicales* 24, 1 (1990): 17-20; D. Shephard and A. Lévesque, *Norman Bethune: His Times and His Legacy* (Ottawa: Canadian Public Health Association, 1982); Wendell MacLeod, Libbie Park and Stanley Ryerson, *Bethune, The Montreal Years: An Informal Portrait* (Toronto: J. Lorimer, 1978); Roderick Stewart, *The Mind of Norman Bethune* (Toronto: Fitzhenry and Whiteside, 1977); Sydney Gordon and Ted Allan, *The Scalpel, The Sword: The Story of Dr. Norman Bethune* (Toronto: McClelland and Stewart, 1971).

21. MSHC Archives, Box 18, File 2, Historical Records, "Medical Report-1938" submitted by D.L. Mendel, Medical Superintendent; "Report of the President-1938" submitted by Louis Salomon. According to a newspaper article, Abe Bronfman claimed it was the first sanatorium in Quebec to provide streptomycin free of charge to those patients who required it. See "Mount Sinai Reduces T.B. In Community," *Gazette* [Montreal], 4 August 1949.

Architects

Mount Sinai architects Spence & Goodman, both based in Montreal, brought diverse institutional design experience to the project. C. Davis Goodman (1894-1962) was a consultant on the Jewish General Hospital of 1930-31.²² MIT-trained David Jerome Spence, (1873-1955) was best known for the grandiose Linton Apartments on Sherbrooke St West and the handsome Hogan Bath building in Pointe-St-Charles. In 1906, he had designed philanthropist Jeffrey Burland's house on Pine Avenue, near the Montreal General Hospital. Burland was devoted to the anti-tuberculosis movement and founded the Montreal Chest Institute. Goodman and Spence seem to have worked together on only two projects: Mount Sinai and the 1948 Philips Square Building. Their differing religions were a crucial aspect of their association in both cases. Spence was Roman Catholic; when prominent Jewish Montrealer Allan Bronfman hired him and F. David Mathias to design the Philips Square Building, Bronfman apparently insisted on having a Jew involved.²³

Likewise, the Laurentian Sanatorium looked to the architectural history of its own religious community and especially to American hospitals. The Laurentian hospital echoed the United States' premier destination for consumptives, Saranac Lake, New York, a place with clearly identifiable architectural links to Ste-Agathe (paralleling medical connections already mentioned). Industrialist Douglas Lorne McGibbon, the major supporter of the Laurentian Sanatorium, had been treated at Saranac Lake for tuberculosis. Architects Scopes & Feustmann, who operated an office at Saranac Lake, designed the Laurentian hospital.²⁴

From its inception, the Laurentian Sanatorium faced chronic bed shortages and operating deficits. A solution to these problems was found in the aftermath of the First World War, when the sanatorium acquiesced to the federal government's request to treat consumptive soldiers and sailors and transfer all moveable and immovable property. In return, Ottawa assumed all the sanatorium's debts and financed new equipment and the expansion of the facility in order to accommodate more patients. A year later, the provincial and federal governments agreed to share the cost of improvements to the Laurentian Sanatorium, which included building five patient pavilions, a power house, a heated tunnel between the service building and the pavilions, and a recreational and vocational

22. Sandra Cohen-Rose wrote a short biographical statement on Goodman and sent it to the Canadian Centre for Architecture. Her letter is dated 10 December 1981.

23. Recollections of F. David Mathias noted by Robert Lemire, Canadian Centre for Architecture, 11 November 1981.

24. Maurice Mayer Feustmann was also Jewish. He worked on a North American campaign to build a welfare centre for Jews at Saranac Lake. See "Pledge \$6,000 at Saranac," *New York Times*, 5 September 1923, 19.

building.²⁵ By 1924, the federal government had bowed out of this relationship by relocating soldier patients to military hospitals and handing over the Laurentian Sanatorium to the provincial government. In May 1925, Quebec arranged to pay an annual grant to maintain the sanatorium and to transfer the land and buildings to the Laurentian Sanatorium Association; the facility accepted to treat consumptives and establish a medical research program.²⁶

The Hospital Site

While traditional architectural history focuses on the ways monuments look, the cultural landscapes approach pioneered by Herman, Upton and others encompasses more modest buildings. Herman's "embedded landscapes" approach to the Charleston single house, in particular, looked at spatial hierarchies as clues to power relationships. In our comparative study of two hospitals, the siting of the two sanatoria was strikingly dissimilar, although both hospitals offered their patients stunning views of the landscape. Mount Sinai was built as an autonomous institution within a surprisingly hierarchical landscape. An aerial photograph (fig. 2) shows the highly ordered 65 hectare (160 acre) site. It accommodates a large, centralized 92-bed pavilion with detached staff quarters erected behind. These were handsome, modern buildings by Montreal architect Reuben Fisher and others. Designed as an independent urban community in the country, Mount Sinai had high-pressure fire equipment, a central heating plant, an ample water supply with continuous hot water, sewage disposal plant, and separate laundry facilities. In other words, everything necessary for the operation of the institution was at hand on site. There were few reasons for patients to ever leave the grounds, nor for outsiders to enter. The aerial photograph also shows the view from the sanatorium with its strict axiality, formality, and geometrical precision. The rigid, geometrical layout enacted the urge to civilize and control disease and to help those unable to help themselves. By recalling the tradition of elite European gardens, such as the landscape surrounding the Chateau de Versailles in France, the landscape also reinforced existing class relations regulating its working-class clientele who resisted middle-class notions of propriety embodied in institutional rules. The message in Mount Sinai's landscape plan came from its distinctiveness from the surrounding village and natural surroundings.

25. McGill Archives, McGill University Health Centre, Montreal Chest Hospital Fonds, Box 7, File 4, Historical Documents, Howard Murray, *Royal Edward Laurentian Hospital: Its History. An Aide-Memoire*, unpublished paper, 1950, 2-3.

26. *Ibid.*, 3-4.

Figure 2. This aerial photo of Mount Sinai Sanatorium shows the hospital's geometrical gardens, island, and view of the distant mountains.



Source: MSHC Archives, Box 17, Photographs.

In contrast, the Laurentian hospital overlooked Lac des Sables in the heart of the town of Ste-Agathe; it had a close and dependent relationship to its geographic and architectural surroundings. The landscape at the Laurentian Sanatorium was inspired by English traditions; it drew directly from the world of the aristocratic English, picturesque country garden with its undulating lawns and seemingly natural vegetation to express a different type of control. Picturesque gardens look natural but they are as planned and planted as geometrical landscapes such as the one at Versailles. Trees and flowers blossom and change in carefully choreographed sequence, emphasizing layers and views; topography, careful terracing, and ground cover seem left over from a long-lost agricultural era. Monumental public parks such as Central Park, in New York City, and Mount Royal Park in Montreal (both by Frederick Law Olmstead) showcased the same ideals in public spaces. The description of the Laurentian Sanatorium's building in the institution's annual reports emphasizes its British roots and its significant relationship to the town of Ste-Agathe:

For those who were not so fortunate as to visit Ste. Agathe at that time, I would like to draw a mental picture of an Elizabethan Colonial Building, nestling in the curve of a forest covered horse-shoe hill which protects it from the winter gales of the North and sunshine of the South throughout the day. Vistas through the various Laurentian Valleys feast the eye in all directions, while at the foot of the grounds lies the Village of Ste. Agathe.²⁷

27. Montreal Chest Institute, Library, Laurentian Sanatorium, Annual Report for 1911, 4.

Food Production

Like Mount Sinai's site plan, the design of facilities for food production at the Jewish sanatorium was self-contained and autonomous. Food for staff and patients was produced and prepared on site. By 1922, the newly-founded Jewish Community Council of Montreal (or *Va-ad ha-'Ir*) set the standards of *kashrut*—the Jewish dietary laws—and a *mashgiach* supervised the Mount Sinai kitchens daily to ensure that food preparation and its storage followed the laws. The cost effective and self-sustaining sanatorium farm raised stock and fowl and grew vegetables and grain. There was even a dovecot on the property. *Kashrut* prescribes precise rules for the slaughter of animals and poultry by a *shochet*, including the pigeons, an important cultural and religious identifier.²⁸ These rules determine which foods could be eaten (for example, pork, shellfish, and certain types of fish are forbidden), prohibit the mixing of meat and dairy products, and deem that dishes, cutlery, pots and pans, and cooking utensils used to prepare meat be kept separate from those used to prepare dairy.²⁹ Even dishwashing requires separate sinks, dish pans, and dishwashers.

At Mount Sinai, Jewish holidays and religious ceremonies required special food products and preparations. Passover Seders were held in the dining room complete with the requisite kosher wine and food. Jewish patients substituted leavened bread with matzo; meals were served on a completely different set of dishes.³⁰ The institution's first dietician described the numerous sets of dishes the kitchen staff handled: "I can tell you there were milk and meat dishes for the patients, separate sets for our dining room, and another 'non kosher' set for the domestics' dining room. Can you imagine the work of changing the five sets for Passover?"³¹ For the festival of Sukkot, which celebrates the harvest and commemorates the 40-year period Jews wandered in the desert after the Exodus from Egypt, a temporary structure called a sukkah was constructed on the premises. In 1926, Sir Mortimer B. Davis donated grapes for Sukkot, likely to decorate the sukkah.³²

28. According to Ira Robinson, access to kosher meat provided newcomers with a connection to European Jewish life. For more on this and the so-called kosher war of 1922-1925 see his article, "The Kosher Meat War and the Jewish Community Council of Montreal, 1922-1925," *Canadian Ethnic Studies* 22, 2 (1990): 41-2.

29. Unfortunately, the plan of the level that included the kitchens has not survived.

30. For more on food, dietary customs, and laws, see Weinfeld, *Like Everyone Else... But Different* (Toronto: McClelland and Stewart, 2001).

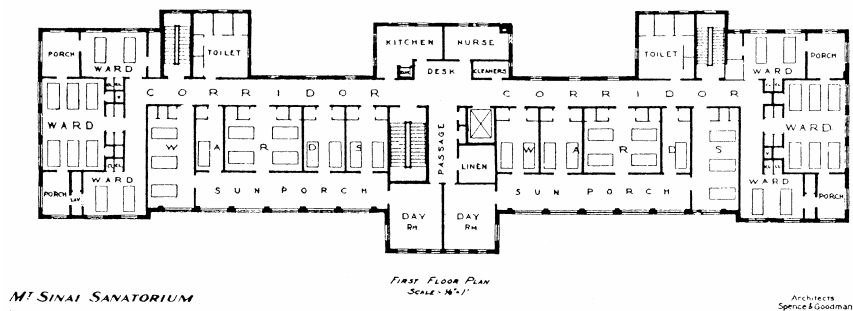
31. MSHC Archives, Box 18, File 2, Historical Records, letter from unidentified ex-employee, 18 March 1998.

32. "Our Thanks," *The Tablets*, 15 October 1926.

Ward Planning

The floor plan (fig. 3) of Mount Sinai Sanatorium was distinctive, particularly its ward configuration. Like many urban convents, schools, and apartment buildings, it was a block plan of I-, H- and T-shapes to maximize light. But at Mount Sinai the rooms located on outside walls were not patient wards, as we might expect. The architects sandwiched multi-bed wards between the light-filled corridor to the rear and shared sun porches on the front of the building, foreshadowing the “racetrack” plan that would become popular for high-rise hospitals after the Second World War. The togetherness of patients was thus facilitated by or, to use Herman’s term, embedded in the hospital’s plan. All the windowless rooms at the building’s core gave on to the same communal space, the sun porch, which was just wide enough for a bed, and two day rooms clustered in the centre of the plan adjacent to the central stairs and elevator core. The nurses’ desk was located at the back of this central section, with access to a small office and kitchen. Toilets, additional stairs, two- and six-bed wards and tiny corner porches marked the widening ends of the hospital’s rectangular footprint. Every bed had a radio connection, reinforcing a sense of community through communication and shared experiences.

Figure 3. Mount Sinai Sanatorium had an unusual floor plan in which the patient spaces occupied the centre of the building.



Source: Canadian Hospital 9, 5 (1932): 16.

Communal Spaces

Wards and sun porches were not the only opportunities for building community at Mount Sinai. For example, Mount Sinai’s flat roof, its elegant synagogue, and a state-of-the-art theatre were also major places of gathering in the Jewish institution. The temple occupied the most significant spot in the hospital, in the front of the building, on the third

floor. Its dominance was marked by a copper dome. Historic photographs (fig. 4) of the synagogue show that the elegant, rectangular synagogue boasted a cove ceiling trimmed with a classical frieze. Its tall, arched, stained-glass windows, each featuring seven Stars of David and pivoting on a single hinge, overlooked the facade of the building. At the front of the synagogue an ark of the covenant contained the holy scrolls; its face is covered with an archetypal red curtain or *parochet*. On its top was a decorative motif of the Ten Commandments, and before it stood a reader's table or *bima* for torah readings, and large and small pews to separate the sexes (the small ones are for the women). An assortment of tables and chairs were used by the cantor and rabbi. A wooden shelf holding markers for the readers hung on the wall beside the ark, decorative menorahs graced the *bima*, and lush fabrics (often satin or velvet in red or maroon, and sometimes royal blue) adorned the ark and *bima*. Although the synagogue served primarily as a site of gathering for worship, it also functioned as a retreat from the mayhem and lack of privacy in the multiple-bed wards, and possibly as a haven from the prying eyes of staff. On Sundays, for example, novelist Sholem Shtern used the synagogue as a place to write.

Another important communal space at the Mount Sinai Sanatorium was the purpose-built theatre, added to the hospital in 1951. The Ladies' Auxiliary partly funded and furnished this impressive, modern 150-seat auditorium with contemporary push-back seats (it also accommodated eight patients in beds). This space is evidence of direct links between the countryside, the institution, and the larger community in Montreal and New York. Montreal's Jewish community recognized the value of entertainment and ensured regular, recent movie features. George Rotsky, the manager at Montreal's Palace Theatre, and his wife Hilda Litner, a member of the Ladies Auxiliary, arranged for performers to appear at Ste-Agathe.³³ The theatre had two movie projectors and a screen to show feature-length films, as well as a fully-equipped stage with orchestra pit, and a draped curtain. Patients who were unable to attend auditorium events could listen to the activities through a hook-up to their pillow radios.³⁴

33. CJCCC National Archives, Box Mount Sinai Sanatorium, 1912-1988, File no. 15, Mount Sinai Hospital Newsletters and Ephemera, "Ladies' Auxiliary Gives So that Others May Live," in "To Commemorate the Dedication of a Great Achievement," 21 June 1953.

34. CJCCC National Archives, MB1, Series B, Box 11, "Mount Sinai Sanatorium Ladies' Auxiliary," Federation of Jewish Philanthropies of Montreal and Constituent Agencies 34th Annual Report, 11; "Ladies Auxiliary Mount Sinai Hospital," Federation of Jewish Philanthropies of Montreal and Constituent Agencies 35th Annual Report, 15; "Ladies' Auxiliary Mount Sinai Sanatorium," Federation of Jewish Philanthropies of Montreal and Constituent Agencies 36th Annual Report, 13.

Figure 4. *The Mount Sinai Sanatorium synagogue occupied a significant place in the hospital, above the entrance.*

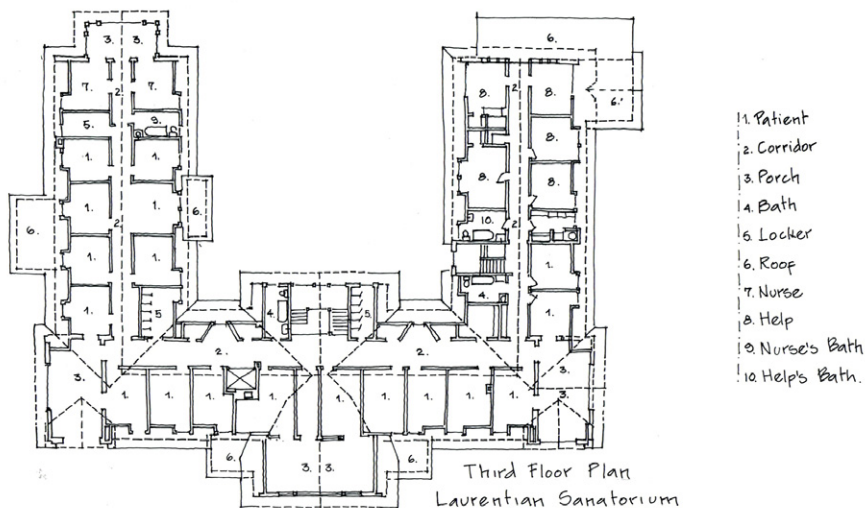
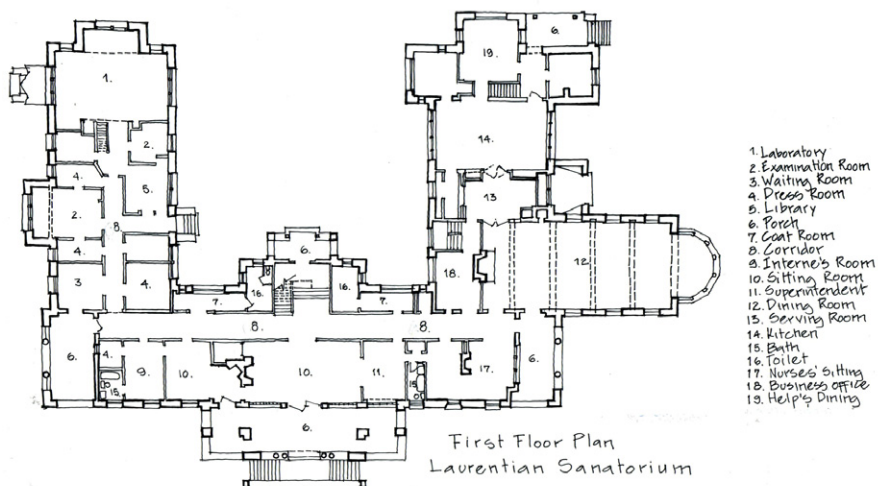


Source: MSHC Archives, Box 18, File 2, Historical Records.

Mount Sinai Sanatorium's isolated site provided opportunities for privacy and intimacy outside the hospital per se. In general, staff members sought to impose a strict regime on a relatively young patient population to ensure its adherence to treatment. Such regulation meant preventing patient truancy—patients sometimes left the hospital to imbibe in the local taverns and hotels of Ste-Agathe—as well as ending any burgeoning intimate relations between patients. Sholem Shtern, who was treated at the Mount Sinai in the 1920s, described patient resistance to the internal discipline of the sanatorium. Patients sought out private places, away from watchful eyes, in the sanatorium, the nearby forest, and outbuildings. This “invisible” use of space recalls the ways slaves sought out alleys and backbuildings in Herman's study of the Charleston single house, and underlines the importance of using both textual and architectural evidence: “The social and symbolic dynamics of buildings are about people and about how people organized aspects of their world through objects and their use,” warns Herman.³⁵ Indeed, Shtern wrote about his own efforts to carry on a romantic relationship, away from the scrutiny of hospital authorities, with a sanatorium nurse whom he eventually married.

35. Herman, 54.

Figure 5. The Laurentian Sanatorium plan resembled a large home and privileged individual ideals rather than communal ones.



Source: Floor plans redrawn by Carlos Rueda Plata from blueprints in the Centre hospitalier Laurentien.

An important difference in the ways the two institutions were experienced, too, came from the room configuration. The buildings' planning (fig. 5) also carefully regulated patient experiences at the Laurentian sanatorium. But at the Protestant hospital rooms were strung along double-loaded corridors which allowed for no incidental meetings and maximum staff supervision. At the Protestant hospital, patients took shelter in the hospital's great pitched roof, like in the attic of a substantial home. Indeed, the notion of the Laurentian Sanatorium sheltering the patient is found throughout the primary sources, frequently in reference to the choice of building materials. In 1911, founder Lorne McGibbon himself described the sanatorium he helped to build in spatial terms, as a "zone of protection":

The building is a substantial one. The foundations are of enduring stone and the whole construction is solidly built to resist in every way the decaying touch of time ... It throws about him a zone of protection that is most needed in our rigorous climate. In fact we should all feel very happy in the knowledge that the Laurentian Sanitarium is making possible a place which everyone would be glad to see shelter those whom they love and cherish when it becomes necessary for them to grapple with this insidious and deadly disease.³⁶

This contrast between individual and communal ideals is also clear if we compare the roofs of the two sanatoriums (fig. 6). The massive gabled roof of the Protestant hospital was an image of protection and security, while the flat roof of the Jewish hospital was a symbol of modernism and an invitation to gather (fig. 7). Before 1951 and in good weather, the roof of the Jewish hospital was used for musical performances. By contrast, the Protestant hospital's dining room was the only space in the entire hospital designed for group interaction. Still, the dining room's design was inspired by domestic imagery: exposed wooden beams, white linen tablecloths, and elegant window dressings. Perhaps because the Laurentian was designed for patients who were not charity cases but rather paid for their lodging and care, the image of the building and its experience was of genteel domesticity. This same home/hospital ambiguity drove the design of private patients' pavilions about this same time. At places like the Ross Memorial Pavilion at the Royal Victoria Hospital and the TJ Bell pavilion at the Toronto General Hospital, architects deliberately engaged luxurious, home-like elements in order to entice paying patients to stay at the hospital.³⁷

36. Montreal Chest Institute, Library, Laurentian Sanatorium, Annual Report for 1911, 4-5.

37. This theme is the subject of a chapter in Annmarie Adams, *Medicine by Design: The Architect and the Modern Hospital, 1893-1943* (Minneapolis: University of Minnesota Press, 2007), 33-69.

Figure 6. This postcard of the Laurentian Sanatorium shows its entry court, dining room, pitched roof, dormer windows, and view of Ste-Agathe-des-Monts.



Source: Digital Collections, Bibliothèque et Archives nationales du Québec. Laurentian sanatorium, Ste Agathe, P.Q.; Carte numéro 1512, CP 1938.

Figure 7. Mount Sinai Sanatorium's flat roof was a place for patients and staff to gather.



Source: MSHC Archives, Box 17, Photographs.

The lack of spaces dedicated to religious functions at the Laurentian Sanatorium is perhaps even starker if we compare its plan to that of a Roman Catholic tuberculosis hospital, such as St. George's Sanatorium in Mont-Joli, Quebec, designed by Auger and Mainguy.³⁸ Roman Catholic sanatoria and hospitals featured consecrated chapels in their programs, often located at the heart of the institution. Like the synagogue at Mount Sinai, chapels in Catholic hospitals were often directly above or accessible from the institution's main entrance. In the case of the Mont-Joli hospital, a stark, modern building with a T-shaped footprint and a ziggurat-like cross section, the chapel occupied almost the entire stem of the "T" on the fourth level. Such a powerful location on axis with the main entry clearly stated the role of religion at the centre of the institution's mission.

Conclusion

What has our architectural comparison of two hospitals in Ste-Agathe, Quebec, shown us about hospital design, the treatment of tuberculosis, and religion? The differences in the institutions were significant: Mount Sinai was hierarchical and centralized—its hospital dominated the smaller buildings on the site—while the Laurentian sanatorium was decentralized, featuring a cluster of multiple pavilions of similar size. At Mount Sinai, windowless multi-bed wards formed the dark core of the building, while patient rooms at the Laurentian hospital got the best light. As we have seen, there were few shared spaces in the Protestant hospital; only the dining room protrudes from the main block of the building. And also unlike Mount Sinai, there is no theatre or religious space of any kind. The largest space at the Laurentian Hospital was for eating, rather than praying, although it served as an entertainment site where movies were shown, and theatre and music concerts took place.

These differences underscore how religion mattered in the treatment of tuberculosis a century ago. It not only determined the inclusion of sacred spaces in religion-based hospitals; it permeated the landscape, kitchen, and ward design. Medical records show that Jewish and Protestant tuberculosis patients received identical therapies; annual reports from the two institutions describe the same concerns over building maintenance, the procuring of equipment, and patient outcomes. Still, the architectural evidence, we contend, reveals major differences in patient experience. Sanatorium treatment for tuberculosis in the early twentieth century was a complex combination of beliefs and ideals, a place where architecture and religious traditions intersected profoundly.

38. On St. George's Sanatorium, see *Journal of the Royal Architectural Institute of Canada* 17, 1 (1940): 6-7; Shelley Hornstein, "The Architecture of the Montreal Teaching Hospitals of the Nineteenth Century," *Journal of Canadian Art History* 13, 2 and 14, 1 (1990-91): 13-25.